

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 1-22-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that orthotics, unlisted modalities, paraffin bath, radiologic examination, therapeutic exercises, chiropractic manipulative therapy, muscle testing and office visits from August 19th through October 6th of 2003 were not medically necessary. Consequently, the requestor is not owed a refund of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On May 4, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Review of the requester's and respondent's documentation revealed that neither party submitted copies of the EOB for the TWCC 73 Work Status Report on 8-19-03. However, review of the recon HCFA reflected proof of submission. Therefore, the disputed service or services will be reviewed according to the Medicare Fee guidelines. Recommend reimbursement of CPT Code 99080-73 for date of service 8-19-03 for \$15.00.

ORDER.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003; in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (b); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 8-19-03 through 10-6-03 in this dispute.

This Decision and Order is hereby issued this 29th day of September 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

April 26, 2004

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M5-04-1437-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

This patient was injured on his job when he tripped over a pallet and injured his right wrist, then later that same day he was loading pipes and his 3rd digit on the left hand was crushed by a pipe, causing the need for surgery. He had an open reduction, internal fixation of the proximal phalanx of the affected digit on July 31, 2003. This surgery was performed by Dr. D. Records indicate that the patient was receiving physical therapy and records which are included in this file indicate that the patient still had restricted range of motion on the left finger. The patient was seen by Dr. P for a designated doctor

evaluation on July 18, 2003, about ____ year after the accident. ____ was assessed an 8% impairment with MMI as of that date. The patient changed doctors to Dr. B on August 7, 2003. There were noticeable restrictions of range of motion indicated by Dr. B's records and eventually the patient underwent further surgical intervention to the affected digit in the form of a contracture release of the MCP of the left 3rd digit with excision of fibrotic tissue, tenolysis of the extensor, removal of the hardware, neurolysis of the digital nerve and tenolysis of the flexor tendon. The surgery occurred on October 28, 2003.

DISPUTED SERVICES

The carrier has denied the medical necessity of orthotics, unlisted modalities, paraffin bath, radiologic examination, therapeutic exercises, chiropractic manipulative therapy, muscle testing and office visits from August 19th of 2003 through October 6th of 2003.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The reviewer finds that the care rendered was not reasonable considering exhaustive care that had been rendered on this case prior to the change of doctor. While it was clear that the patient was in need of further surgery, from the notes of the treating doctor and all of the referrals, it was not reasonable to think that extremely extensive care would have helped prevent this patient from receiving this surgery. There is no indication that the care rendered had a positive effect on the patient and the care rendered should have been rendered after the extensive care that had already been rendered. As a result, the reviewer finds that the care rendered was neither reasonable nor necessary in this case.

____ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ____ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ____, I certify that there is no known conflict between the reviewer, ____ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

____ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,